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In The Supreme Court of the United States

ALBERTO R. GONZALES, Attorney General,

Petitioner,

v.

LEROY CARHART, *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF *AMICI CURIAE* CONGRESSMAN RON PAUL AND ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS IN SUPPORT OF PETITIONER

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INTEREST OF THE *AMICI CURIAE*[1]

This *amici curiae* brief is respectfully submitted on behalf of Congressman Ron Paul and the Association of American Physicians and Surgeons in support of Petitioner and in favor of reversal of the judgment of the United States Court of Appeals for the Eighth Circuit entered on July 8, 2005.

Amicus curiae Congressman Ron Paul, M.D., graduated from the Duke University School of Medicine and served as a flight surgeon in the U.S. Air Force during the 1960s. In 1968, he began practicing medicine in Texas, as a specialist in obstetrics and gynecology. He has delivered more than 4,000 babies. He served in Congress in the late 1970s and early 1980s, then voluntarily relinquished his House seat to return to his medical practice. He returned to Congress in 1997 where he represents the 14th Congressional district of Texas.

Amicus curiae, the Association of American Physicians & Surgeons, Inc. ("AAPS"), is a nonprofit organization dedicated to defending the practice of private medicine. Founded in 1943, AAPS has thousands of members nationwide in all specialties. AAPS frequently participates in litigation in defense of the practice of medicine in accordance with the Oath of Hippocrates. Central to the interest of AAPS is protecting the profession against procedures which, like the one at issue here, are not designed to promote and protect the health of the patient.

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[1] The parties have consented to the filing of this brief. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the *amicus curiae*, its members, or its counsel made a monetary contribution to the preparation and submission of this brief.

SUMMARY OF THE ARGUMENT

At the heart of this dispute is the question of Congress' competence to make two factual determinations. First, that "partial-birth abortions are 'ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb'". Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 § 2.14(I). Second, that:

> [a] moral, medical and ethical consensus exists that the practice of performing a partial-birth abortion – an abortion in which a physician delivers an unborn child's body until only the head remains inside the womb, punctures the back of the child's skull with a sharp instrument, and sucks the child's brains out before completing delivery of the dead infant – is a gruesome and inhumane procedure that is never medically necessary and should be prohibited.

Id. at § 2.1. The federal ban of partial-birth abortion was found to be unconstitutional, based not upon the legislative record accumulated over years of Congressional hearings on these issues but on newly created evidence prepared for and presented to the District Court below, because no exception was made for performance of the procedure when a physician determined it was necessary for the health of the mother.

The lower courts erred in four critical ways. By reviewing the evidence with no presumption in favor of Congress' judgment, the District Court failed to show any deference to the legislative branch and its lawmaking authority under the Constitution. The court embraced on open-ended definition of health that would make any prohibition of partial-birth abortion purely illusory, accepting the plaintiffs' argument that abortion is safer than carrying a child to term, regardless of when the abortion occurred during gestation. Congressional

concerns that the unborn child experiences pain during abortion, and that this pain could be minimized by inducing fetal demise prior to performance of the abortion were dismissed as "capricious." *Carhart v. Ashcroft*, 331 F.Supp. 2d 805, 1029 (D. Neb. 2004). In affirming those rulings, the Court of Appeals relied upon a reading of *Stenberg v. Carhart*, 530 U.S. 913 (2000) that a majority of this Court expressly disavowed – one which read *Stenberg* as creating a *per se* requirement of a health exception.

Each of these errors is grievous and, if uncorrected, threatens grave mischief among the lower courts. Absent the historical deference this Court has shown the legislative branch in its lawmaking function, the delicate Constitutional balance created by the framers to insure collective self-governance is lost. Accepting an unsubstantiated claim that abortion is always safer than completion of a pregnancy insures that "abortion-on-demand" becomes reality in the guise of protecting women's health. Denying the legitimacy of governmental concern for fetal pain writes into the Constitution a form of selfish egoism that has no foundation in the American character. Finally, to create a *per se* requirement of a health exception for any abortion regulation continues down the path of judicial construction of an "abortion code," rather than application of Constitutional analysis.

ARGUMENT

I. THE DISTRICT COURT ERRED IN SUBSTITUTING ITS JUDGMENT FOR THAT OF CONGRESS AND THE PRESIDENT.

This Court has long recognized the shared responsibility of all "who [] have taken the oath to observe the Constitution and who have the responsibility for carrying on government." *Rostker* v. *Goldberg*, 453 U.S. 57, 64 (1981).

"We owe Congress' findings deference in part because the institution 'is far better equipped than the judiciary to "amass and evaluate the vast amounts of data" bearing upon' legislative questions," and "an additional measure of deference out of respect for its authority to exercise the legislative power." *Turner Broadcasting System, Inc.* v. *Federal Communications Commission*, 520 U.S. 180, 195 (1997) (*Turner II*). As a reflection of the shared, but diverse responsibilities of the co-equal branches of government, this Court has been (and has cautioned lower courts to be) "particularly careful not to substitute our judgment of what is desirable for that of Congress, or our own evaluation of evidence for a reasonable evaluation by the Legislative Branch." *Rostker* v. *Goldberg*, 453 U.S. 57, 64 (1981).

The District Court disregarded this caution, substituting its own evaluation of newly created evidence presented at trial, instead of engaging in a careful review of whether Congress had drawn reasonable inferences based upon the substantial evidence amassed during the years of Congressional hearings on this legislation. *Cf. Turner Broadcasting System, Inc.* v. *Federal Communications Commission*, 512 U.S. 622, 666 (1994) (*Turner I*). By asking and answering the question, "Is there substantial evidence in the relevant record from which a reasonable person could conclude that the banned procedure is *never necessary, in appropriate medical judgment,* for the preservation of the health of the woman?" *Carhart v. Ashcroft*, 331 F.Supp. 2d 805, 1008 (2004) (emphasis in original), the District Court gave little or no weight to the considered judgment of Congress. This is plain error and requires reversal of the judgment.

II. THE DISTRICT COURT ADOPTED A DEFINITION OF HEALTH THAT RENDERS ANY ABORTION REGULATION ILLUSORY.

In formulating the partial-birth abortion ban, Congress was informed by extensive hearings held during the 104th, 105th, and 107th Congresses. These proceedings revealed that neither the American Medical Association nor the American College of Obstetricians & Gynecologists could identify any maternal conditions requiring the use of D & X abortion. H.R. Rep. No. 108-58 at 15-16. Maternal health specialists testified consistently that there was no need for the procedure's use.[2] Perhaps of greatest import, Congress learned that the term "health" was offered by some abortion providers as justification for performing any abortion.

> Dr. Warren Hern of Colorado, the author of the standard textbook on abortion procedures who also performs many third-trimester abortions has stated: "I will certify that any pregnancy is a threat to a woman's life and could cause grievous injury to her physical health." Thus, including a health exception in the ban would render the ban meaningless, as it would not prohibit a single partial-birth abortion.

H.R. Rep. No. 108-58 at 19.

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[2] *See, e.g., Partial-Birth Abortion Ban of 2002: Hearing on H.R. 4965 before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 107th Cong. (2002) (testimony of Curtis Cook, M.D.) available at http://judiciary.house.gov/legacy/80553.pdf; *Partial-Birth Abortion: The Truth, Joint Hearing on S. 6 and H.R. 929 before the Senate Comm. on the Judiciary and the House Comm. on the Judiciary*, 105th Cong. (1997) (testimony of Curtis Cook, M.D.) available at http://judiciary.house.gov/legacy/22236.htm; and *Partial-Birth Abortion Ban of 2002: Hearing on H.R. 760 before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 108th Cong. (2003) (testimony of Mark Neerhof, M.D.) available at http://judiciary.house.gov/legacy/85987.pdf.

Notwithstanding this clear and legitimate expression of Congressional concern, the District Court embraced Dr. Hern's fallacious definition of health as its first specific determination. "Childbirth is more dangerous to the health of women than abortion." 331 F.Supp. 2d at 1017.

> When objectively trying to assess the danger of abortion procedures, one must start with childbirth. That is, absent an abortion, what are the risks of childbirth? In general, childbirth is more dangerous than abortion, particularly when the fetus is not viable and when the woman is older. As Dr. Maureen Paul – a board-certified obstetrician and gynecologist, an expert in abortion, and an epidemiologist – put it, abortion is "hands down" a safer option than carrying a pregnancy to term. (Pls.' Ex. 125, at 38.) Thus, any assertion that a particular abortion method is risky must be judged against the generally more dangerous alternative of childbirth.

Id. at 1018. So defined, a "health exception" to any limitation of partial-birth abortion can be invoked by any abortion provider to permit use of the procedure at any time. *Cf. Stenberg v. Carhart*, 530 U.S. 913, 1012-13 (2000) (Kennedy, J. dissenting) ("If Nebraska reenacts its partial birth abortion ban with a health exception, the State will not be able to prevent physicians like Dr. Carhart from using partial birth abortion as a routine abortion procedure. This Court has now expressed its own conclusion that there is "highly plausible" support for the view that partial birth abortion is safer, which, in the majority's view means that the procedure is therefore "necessary." *Ante,* at 2612. Any doctor who wishes to perform such a procedure under the new statute will be able to do so with impunity.").

Assuming *arguendo* that the proper measure is the relative safety of pregnancy versus legally-induced abortion, the District Court's conclusion is not supported by

reliable comparative data. Prolife and prochoice experts have criticized the American abortion data collection system.

Stanley K. Henshaw, Senior Research Fellow of the Guttmacher Institute, the research affiliate of Planned Parenthood, has noted that there is currently no way of accurately determining the number of abortions performed in this country:

> Most states have incomplete reporting of abortions despite reporting requirements, some have voluntary reporting, and one has no reporting system. Trends in the numbers of reported abortions are unreliable because of changes in the facilities that agree to report. Even states with complete reporting are unable to accurately measure the number of their residents who have abortions, because some neighboring states have incomplete data or do not share data.

Stanley K. Henshaw, *Birth and Abortion Data* in Doug Besharov, ed., DATA NEEDS FOR MEASURING FAMILY AND FERTILITY CHANGE AFTER WELFARE REFORM (2001) at 57 available at http://www.welfareacademy.org/pubs/dataneeds/dataneeds.pdf.

There is also serious concern regarding the underreporting of abortion complications. "The abortion reporting systems of some countries and states in the United States include entries about complications, but these systems are generally considered to underreport infections and other problems that appear some time after the procedure was performed." Stanley K. Henshaw, *Unintended Pregnancy and Abortion: A Public Health Perspective*, in A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTIONS 20, 20 (Maureen Paul *et al.*, eds. 1999). *See also* J. Richard Udry *et al.*, *A Medical Record Linkage Analysis of Abortion Underreporting*, 28 FAM. PLAN. PERSP. 228, 228 (1996) ("The primary limitation of many U.S. studies is that they use data on

average characteristics of abortion patients, rather than directly matching records, and they rely on complicated algorithms and corrections that introduce opportunities for measurement error."); Haishan Fu *et al.*, *Measuring the Extent of Abortion Underreporting in the 1995 National Survey of Family Growth*, 30 FAM. PLAN. PERSP. 128 (1998); Audrey F. Saftlas *et al.*, *Pregnancy-Related Morbidity*, in FROM DATA TO ACTION: CDC'S PUBLIC HEALTH SURVEILLANCE FOR WOMEN, INFANTS, AND CHILDREN 129, 137 (1994), available at http://www.cdc.gov/reproductivehealth/Products&Pubs/DatatoAction/pdf/rhow10.pdf ("no nationally representative data about legal abortion-related morbidity have been available or collected since the 1970s"); and National Right to Life, *Abortion in the United States: Statistics and Trends* (noting difficulties with underreporting and estimating the number of abortions) available at http://www.nrlc.org/abortion/facts/abortionstats.html.

Perhaps more importantly, the Centers for Disease Control do not use the same standard for reporting abortion-related deaths and pregnancy-related deaths.

> The maternal mortality rate is computed as all maternal deaths per 100,000 live births. In contrast, the measure used for abortions is a case-fatality rate which is computed per 100,000 abortions. These measures are conceptually different and used by CDC for different public health purposes.

Letter from Julie L. Gerberding, M.D., M.P.H., Director, to Walter M. Weber, American Center for Law & Justice (July 20, 2004) (reproduced as Appendix A).

When using a single uniform standard for mortality, recent analyses of large medical databases linked to death certificates have shown that significantly higher mortality rates are associated with abortion. "These record linkage studies have demonstrated that pregnancy-associated deaths are actually two to four times higher for aborting

women compared to delivering women." David C. Reardon *et al., Deaths Associated with Abortion Compared to Childbirth – A Review of New and Old Data and the Medical and Legal Implications*, 20 J. CONTEMP. HEALTH LAW & POL'Y 279, 281 (2004).

The willingness of some abortion providers and courts to define any pregnancy as a health risk justifying abortion and the difficulty in obtaining reliable comparative data regarding the relative safety of continuation and termination of pregnancy support Congress' determination that a health exception is neither necessary nor desirable in this legislation.

III. THE DISTRICT COURT PERMITTED MERE SPECULATION TO OUTWEIGH THE REASONABLE JUDGMENT OF CONGRESS.

The District Court faults Congress for determining that partial-birth abortion is no safer than D & E. This judgment, however, reflects the Court's failure to limit its inquiry to what the plaintiffs proved, rather than what they preferred. A clear example of this can be found in the differing manner in which courts have summarized the testimony of Dr. Stephen Chasen, one of the authors of the only peer-reviewed study comparing D & X and D & E abortions. Dr. Chasen testified before the United States District Court for the Southern District of New York regarding this law. A transcript of Dr. Chasen's testimony was submitted to the Nebraska District Court. Trial tr. at 752. (A partial transcript of Dr. Chasen's testimony is reproduced as Appendix B).

The Court of Appeals for the Second Circuit summarized Dr. Chasen's testimony regarding any comparative advantages of D & X derived from his study as follows:

> Dr. Chasen testified that there was no difference between the two procedures in either procedure

> time or blood loss. The District Court was correct that the Chasen study fails to support any of the claimed safety advantages of D & X. The Chasen Study found no difference in blood loss or procedure time between D & X and D & E. The two procedures have "similar" complication rates. Dr. Chasen admitted that the study did not prove that D & X is superior to D & E. He also testified that the study could not claim that D & X was "as safe as" D & E.
>
> The study showed that for the small group of women for whom subsequent pregnancy information was available, spontaneous birth occurred in 2 of 17 (11.8%) of the D & X group, and 2 of 45 (4.4%) of the D & E group. Although this difference may be statistically insignificant given the few patients in the study, it was sufficient to signal a cause for concern for some of the experts. The study also showed that the D & X group experienced a higher rate of cervical laceration (2.4%) than the D & E group (.8%). Dr. Sprang derived this number from the data in the Chasen study. While the sample size was too small to be statistically significant, it "tends to show that D & X has the potential to cause more trauma to the cervix." Trial Tr. at 2125.

Nat'l Abortion Federation v. Gonzales, 437 F.3d 278, at 308-09 (2nd Cir. 2006) (Straub, J. dissenting).

After reviewing the exact same testimony, the District Court below summarized Dr. Chasen's testimony regarding the study as:

> The complication rates for the two groups were identical, but the serious complications (uterine perforation, amniotic fluid embolus, sepsis, and pulmonary embolus) all occurred with dismemberment D & E. These complications could not have been avoided by performing an intact D & E because that procedure was not feasible on those

> patients. There is generally a higher rate of complications associated with abortions performed at later gestational ages. However, in the Chasen study, the rate of complications was the same for the intact D & E procedure (average gestational age of 23 to 24 weeks) compared to the dismemberment D & E procedure (average gestational age of 20 to 21 weeks). Although not proved with certainty by the study data, Dr. Chasen believes that since each serious complication occurred in the dismemberment D & E group, and the intact D & E group did not have a higher complication rate despite the higher risk of complications due to greater gestational age, the intact D & E has safety advantages over the dismemberment D & E.

331 F.Supp. 2d at 961.

The variation in these summaries might be discounted as simply a matter of emphasis on different parts of the testimony if this were a case involving the standard of care for a medical malpractice suit, with no legislative guidance regarding the comparative safety of the procedures at issue. Such an excuse is not available in this case, however, where the decisive question is whether Congress has reached a reasonable conclusion supported by substantial evidence. *See Turner II*, 520 U.S. 180 at 211 (1997). The District Court apparently elevated the subjective beliefs of Dr. Chasen over both his testimony regarding the objective results of his own comparative study of partial-birth abortion and other methods, as well as the considered judgment of Congress.

The subjective nature of the District Court's review is perhaps best summarized in the following passage from its opinion:

> In order to find that the banned procedure is not safe or not needed, I would have to find that the

> numerous and extraordinarily accomplished surgeons who gave testimony in this case and who routinely use the banned technique throughout this country, many at major metropolitan hospitals, do not know what they are doing. For example, despite her stellar background and vast experience, I would have to conclude that Dr. Marilynn Frederiksen is a quack.

331 F.Supp. 2d 1024.[3] To confuse the legal standard of whether Congress has reached a reasonable conclusion supported by substantial evidence when banning partial-birth abortion with a question of the professional competence of the experts appearing before the Court illustrates the failure of the District Court to employ the proper standard of review.

IV. *STENBERG* DOES NOT DENY CONGRESS THE ABILITY TO REASONABLY RESOLVE QUESTIONS RELATED TO PUBLIC HEALTH.

The Court of Appeals for the Eighth Circuit affirmed the District Court, ruling that *Stenberg v. Carhart*, 530 U.S. 914 (2000) adopted a *per se* requirement of a health exception for abortion regulations. *Carhart v. Gonzales*, 413 F.3d 794, 800 (8th Cir. 2005). Justice Breyer specifically disavowed this interpretation of *Stenberg* that the government was without powers to regulate and even prohibit certain means of abortion. "This is not to say, as

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[3] At another point in its opinion the District Court rejects the testimony of two of the government's experts because they are "too rigid in their beliefs," noting later that "both the law and common courtesy shield Dr. Sprang and Dr. Cook from criticism regarding their personal decisions not to perform abortions." 331 F.Supp. 2d 1024. The implicit hostility in this unnecessary dicta can not help but fuel public perceptions that abortion jurisprudence is more a matter of the personal political views of the judge than the application of constitutional mandates.

Justice Thomas and Justice Kennedy claim, that a State is prohibited from proscribing an abortion procedure whenever a particular physician deems the procedure preferable. *By no means must a State grant physicians 'unfettered discretion' in their selection of abortion methods.*" *Stenberg*, 530 at 936 (emphasis added). To deprive government of its ability to legislate in this area would prove inimical to the health and well being of women. *See, e.g., McCorvey v. Hill*, 385 F.3d 846, 850 (5th Cir. 2004) (Jones, J. concurring) (case involving about "a thousand affidavits of women who have had abortions and claim to have suffered long-term emotional damage and impaired relationships from their decision"); and *Women's Medical Ctr. of N.W. Houston v. Archer*, 159 F.Supp. 2d 414, 427 (S.D. Tex. 1999) (abortion provider testified to "the cattle herd mentality" in some abortion clinics).

The conflict arises in this case from Justice Breyer's next observations. "But where substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women's health, *Casey* requires the statute to include a health exception when the procedure is 'necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'" *Stenberg*, 530 at 936. The question in this dispute is "do unsubstantiated beliefs, even when held by prominent medical professionals, constitute 'substantial medical authority.'"

In an increasingly pluralistic society, the answer must be no.

Just last term this Court affirmed the ability of Congress to prohibit the sale of marijuana, notwithstanding that at least nine states had statutes authorizing its sale and use for medicinal purposes. *Gonzales v. Raich*, 545 U.S. 1, 125 S.Ct. 2195 (2005). The Court recognized the conflicting professional opinions regarding the effectiveness of marijuana in treating various medical conditions,

125 S.Ct. at 2212 n.37, and counseled the plaintiffs "even more important than these legal avenues is the democratic process, in which the voices of voters allied with these respondents may one day be heard in the halls of Congress." 125 S.Ct. at 2215.

Similarly in *United States v. Rutherford*, 442 U.S. 554 (1979) a group of terminally ill cancer patients and their spouses argued that the FDA regulations should be construed to imply an exception for the prescription and use of Laetrile by terminally ill patients. Seventeen States had legalized the drug's use for cancer treatment. 442 U.S. at 554 n.10. In rejecting the plaintiffs' claim on behalf of a unanimous court, Justice Marshall wrote, "Under our constitutional framework, federal courts do not sit as councils of revision, empowered to rewrite legislation in accord with their own conceptions of prudent public policy." *Id.* at 554.

In 1996 Congress passed 18 U.S.C. § 116, providing in part that "whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained that age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both." These procedures, known as "female genital mutilation" or female circumcision, are practiced routinely in other parts of the world,[4] and there is some evidence that it is still

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[4] "FGM [female genital mutilation] is most associated with Africa where it is practiced in varying degrees in over half of the Sub-Saharan African countries." Office of the Senior Coordinator for International Women's Issues, Office of the Under Secretary for Global Affairs, U.S. Dept. of State, *Prevalence of the Practice of Female Genital Mutilation (FGM); Laws Prohibiting FGM and Their Enforcement; Recommendations on How to Best Work to Eliminate FGM* (June 27, 2001) at 7, available at http://www.state.gov/documents/organization/9424.pdf (last visited May 15, 2006).

secretly practiced here in the United States.[5] Although the practice within the United States is predominately a matter of ethnic heritage,[6] there are rare cases involving other motivations. *See Turner v. Ostrowe*, 828 So.2d 1212, 1215 (La.App. 1 Cir. 2002).

Some within the medical community believe that doctors should be free to offer a sterile surgical procedure that might satisfy the desire of some immigrants out of the respect for cultural differences and to minimize the risk that girls will be subjected to more dangerous alternatives. Immediately after passage of the federal law, Abraham Bergman, chief of pediatrics at a Seattle hospital, was quoted in the NEW YORK TIMES as saying "I think that this is an issue that should be decided by a physician, the family and the child. Privacy should prevail and the brouhaha is inappropriate."[7] Some doctors propose a "'simple symbolic cut' amounting to a mere 'nick' – enough

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[5] *See id.* 14 (estimating that 48,000 girls in this country under the age of 18 have been or at risk of being subjected to FGM). *See also* Michael Blanding, *Bostonians Changing the World*, BOSTON GLOBE (Apr. 30, 2006) (discussion of women seeking FGM for their daughters at African Women's Health Center at Brigham, MA); Edward Hegstrom, *Gynecologists Report Female Circumcisions; Some Immigrants Had Operation, Study Finds*, HOUS. CHRON. (Dec. 27, 2000) at A19 and Jennifer English, *Man Could Face Kid Porn Charges*, THE DAILY NEWS OF L.A. (Jan. 15, 2004) at SC1 ("Authorities contend that Bertrang, who has a Web site devoted to body piercing, offered in 2002 to perform circumcision on the fictional 8- and 12-year-old daughters of an undercover FBI agent.").

[6] *See* Linda Burstyn, *Health: Female Circumcision Comes to America*, 276 THE ATLANTIC MONTHLY 28 (1995); Barbara Crossette, *Female Genital Mutilation by Immigrants Is Becoming Cause for Concern in the U.S.*, N.Y. TIMES (Dec. 10, 1995) at 1:1; Sharon Lerner, *Rite or Wrong? As the U.S. Law Against Female Genital Mutilation Goes into Effect, African Immigrants Debate an Ancient Custom*, VILLAGE VOICE (Apr. 1, 1997) at 44.

[7] Celia W. Dugger, *New Law Bans Genital Cutting in United States*, N.Y. TIMES (Oct. 12, 1996) at 1:1.

to draw blood, with no tissue removal or subsequent scarring."[8] Other doctors, including the leadership of the American Medical Association, condemn any form of female genital mutilation.[9] "[T]here are some procedures so abhorrent to society that they have been severely restricted or banned." H.R. Rep. 108-58 at 21 (2003). Surely the existence of disagreement within the medical community regarding the desirability of prohibiting this practice does not render the legislative ban unconstitutional.

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[8] Doriane Lambelet Coleman, *The Seattle Compromise: Multicultural Sensitivity and Americanization*, 47 DUKE L.J. 717, 737 (1998) (describing this as the proposed policy of Haborview Hospital in Seattle, Washington in response to repeated requests from the immigrant community); *see also Proposal of "Symbolic" Female Circumcision Raises Ire in Italy*, U.N. WIRE (Feb. 3, 2004) at http://www.unwire.org/UNWire/20040203/449_12718.asp; and Julia Valderrama, *Female Genital Mutilation: Why are We so Radical?*, THE LANCET 529-530 (Feb. 9, 2002).

[9] AMA Policy H-525.980 *Expansion of AMA Policy on Female Genital Mutilation* provides:

> The AMA (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; and (4) supports that physicians who are requested to perform female genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with changing societal mores. (CSA Rep. 5-I-94; Res. 513, A-96).

American Medical Association Policyfinder at http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-525.980.HTM.

Consider yet a final example – that of "body integrity identity disorder."[10] In September 1997 and April 1999, Dr. Robert Smith removed the healthy legs of men who claimed that they would only feel whole when they were amputees.[11] The surgeries were medical successes, in that there were no post-operative complications and the patients publicly proclaimed their satisfaction with the results.[12] It was only when Dr. Smith was consulting with yet a third patient about the possible amputation of a healthy limb that the hospital chairman intervened and stopped the practice.[13] This condition and the legitimacy of providing surgery has been the subject of two international medical conferences at Columbia University Medical Center.[14] The fact that some within the medical community condone the removal of healthy limbs to relieve patients' psychological distress and out of respect for patients' autonomous choices should not render the legislative branch constitutionally impotent in the face of this bizarre practice.[15]

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[10] Information from a sympathetic point of view to the existence of the disorder can be found at the Body Integrity Identity Disorder website at http://www.biid.org.

[11] Clare Dyer, *Surgeon Amputated Healthy Legs*, 320 BRIT. MED. J. 332 (2000) available at http://bmj.bmjjournals.com/.

[12] Andiey Kao, *The Difficult Appendage*, Did You Know? (AMA Virtual Mentor, Sept. 2001) at http://www.ama-assn.org/ama/pub/category/6262.html ("The two patients who requested and received amputations performed by Dr. Smith have voiced great satisfaction and relief that now they feel complete without 4 limbs.").

[13] Randy Dotinga, *Out on a Limb*, Salon.com (Aug. 29, 2000) at http://dir.salon.com/health/feature/2000/08/29/amputation/index.html (describing the reaction of the prospective third patient to rejection by the hospital).

[14] Body Integrity Identity Disorder Website, 2003 Conference Webpage and 2004 Conference Webpage at http://www.biid.org/.

[15] *See* Tim Bayne & Neil Levy, *Body Integrity Identity Disorder and the Ethics of Amputation*, 22 J.APPLIED PHIL. 75 (2005) (arguing in

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In the original case involving partial-birth abortion Dr. Leroy Carhart adopted the practice after hearing of its development by Dr. Martin Haskell.[16] When it became illegal in the state of Nebraska, Dr. Carhart brought a constitutional challenge to the state ban. The federal district court found the Nebraska statute constitutionally infirm because of partial-birth abortion's supposed superior safety,[17] notwithstanding the fact that among all the physician-witnesses appearing at the trial only Dr. Carhart had actually performed a partial-birth abortion.[18] The judgment was ultimately affirmed by a majority of this Court.[19]

What began as a fringe method is attempting to insinuate itself into the mainstream of American abortion

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favor of allowing competent adults to direct physicians to amputate healthy limbs). For a limited discussion of the legality of amputation of healthy limbs, *see* Josephine Johnson & Carl Elliott, *Healthy Limb Amputation: Ethical and Legal Aspects*, CLINICAL MEDICINE 431 (Sept./Oct. 2002) available at http://dandini.ingentaselect.com/vl=11713608/cl=28/nw=1/rpsv/cw/rcop/14702118/v2n5/s13/p. *See also* Carl Elliott, *Costing an Arm and a Leg*, SLATE (July 10, 2003) at http://slate.msn.com/id/2085402.

[16] *See* Martin Haskell, *Dilation and Extraction for Late Second Trimester Abortion* (presented at the National Abortion Federation Risk Management Seminar, Sept. 13, 1992), *published in The Partial-Birth Abortion Ban Act of 1995: Hearings on H.R. 1833 Before the Senate Comm. On the Judiciary*, 104th Cong., 1st Sess. 3 (Nov. 17, 1995).

[17] *Carhart v. Stenberg*, 11 F.Supp. 2d 1099, 1127 (D. Neb. 1998).

[18] Dr. Stubblefield, an expert appearing on behalf of Dr. Carhart "has not performed this procedure himself, nor has he viewed anyone else perform it." 11 F.Supp. 2d at 1112. Similarly, Dr. Carhart's other expert, Dr. Hodgson, "performed or supervised at least 30,000 abortions," (11 F.Supp. 2d at 1105) and yet had never intentionally performed an intact D & X. 11 F.Supp. 2d at 1105, 972 F.Supp. at 516.

[19] *Stenberg v. Carhart*, 530 U.S. 914 (2000).

practice.[20] Abortion providers and their academic allies have failed to establish that the performance of partial-birth abortion is ever necessary to maintain the health of the woman,[21] yet the practice has been incorporated into abortion texts and the curriculum of prestigious medical schools.[22]

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[20] Royal College of Obstetricians and Gynaecologists, THE CARE OF WOMEN REQUESTING INDUCED ABORTION: EVIDENCE BASED CLINICAL GUIDELINE NO. 7 (rev. ed. 2004) rejects the use of partial-birth abortion.

> Published evidence provides reassurance on the safety and efficacy in mid-trimester of both D&E and medical abortion using mifepristone plus prostaglandin. Other methods of mid-trimester abortion have been described. These include:
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> - 'intact D & X' (also termed partial birth abortion)
> - two-stage procedures involving two general anaesthetics (in which the membranes are ruptured and the umbilical cord divided, followed, some days later, by D&E)
> - medical abortion using instillation of various agents.
>
> *There are scant published data on the safety of these methods and, to our knowledge, intact D & X has never been used in the UK. These mid-trimester abortion methods are not recommended for UK practice.*

Id. at 50 (emphasis added).

[21] *See* Amer. College of Obstetricians & Gynecologists, *Statement on Federal Court "Partial-Birth Act" Decision by The American College of Obstetricians and Gynecologists* (June 2, 2004) at http://www.acog.org/from_home/publications/press_releases/nr06-02-04.cfm ("a select panel convened by ACOG could identify no circumstances under which intact D & X would be the only option to protect the life or health of a woman"). A subsequent policy statement by the AMA agreed, finding that "there does not appear to be any identified situation in which intact D & X is the only appropriate procedure to induce abortion." AMA Policy H-5.982, *quoted in Hope Clinic v. Ryan*, 195 F.3d 857, 872 (7th Cir. *en banc* 1999).

[22] The procedure is taught at medical schools located at Albert Einstein, NYU, Cornell University, Northwestern, and the University of California at San Francisco. 331 F.Supp. 2d at 1010.

The only peer-reviewed study of the procedure began during consideration of the passage of the Act at issue in this litigation.[23] *See, e.g.*, 150 Cong. Rec. S.3560-3614 (Mar. 12, 2003). Contrary to the hopes of the plaintiffs, this study merely provides evidence that this brutal practice is no better than existing abortion techniques, while raising (but not answering) questions about the long-term impact of partial-birth abortion on maternal health. *See Nat'l Abortion Federation v. Gonzales*, 437 F.3d 278, at 308-09 (2nd Cir. 2006) (Straub, J. dissenting).

As Justice Kennedy has observed:

> The standard of medical practice cannot depend on the individual views of Dr. Carhart and his supporters. The question here is whether there was substantial and objective medical evidence to demonstrate the State had considerable support for its conclusion that the ban created a substantial risk to no woman's health. *Casey* recognized the point, holding the physician's ability to practice medicine was "subject to reasonable . . . regulation by the State" and would receive the "same solicitude it receives in other contexts." *Ibid.* In other contexts, the State is entitled to make judgments where high medical authority is in disagreement.
>
> The Court fails to acknowledge substantial authority allowing the State to take sides in a medical debate, even when fundamental liberty interests are at stake and even when leading members of the profession disagree with the conclusions drawn by the legislature. In *Kansas v. Hendricks,* 521 U.S. 346, 117 S.Ct. 2072, 138 L.Ed.2d 501 (1997), we held that disagreements

[23] "Dr. Chasen acknowledged that he initiated the study with the knowledge that the Act was pending before Congress." *Nat'l Abortion Federation v. Ashcroft*, 330 F.Supp. 2d 476, n. 24.

> among medical professionals "do not tie the State's hands in setting the bounds of . . . laws. In fact, it is precisely where such disagreement exists that legislatures have been afforded the widest latitude." *Id.*, at 360, n. 3, 117 S.Ct. 2072. Instead, courts must exercise caution (rather than require deference to the physician's treatment decision) when medical uncertainty is present. *Ibid.*

Stenberg, 530 U.S. at 969-70 (Kennedy, J. dissenting).

V. CONGRESS HAS AN INTEREST IN BANNING D & X ABORTIONS TO PREVENT FETAL PAIN.

The District Court below found that the existence of fetal pain was irrelevant to the constitutionality of the ban.

> I am perfectly willing to assume, for the sake of argument, that a nonviable fetus can suffer pain at some point at or after 20 weeks, because nonviable fetal pain is legally irrelevant, it is not necessary, and to be truthful, it is impossible, to decide precisely when, if at all, a nonviable fetus feels pain. The evidence establishes to a virtual certainty that human fetuses lack the anatomy and physiology to perceive pain prior to 20 weeks. After that, the trial evidence convinces me that it is not possible to pinpoint when a fetus develops sufficiently such that it has the physical ability to perceive pain. Following a thorough cross-examination about the different medical opinions on this subject (Tr. 1058-68, Test. Dr. Anand) and the ambiguity of the data, Dr. Anand, the government's credible pain expert who believed a fetus could feel pain at about 20 weeks, admitted that "there is disagreement in the medical community on the issue of whether fetuses, at 20 weeks and later, are able to feel pain."

331 F.Supp. 2d 1027. Judge Hamilton, hearing a related case in the Northern District of California, arrived at the same conclusion. She wrote that "much of the debate on this issue is based on speculation and inference"[24] and that "the issue of whether fetuses feel pain is unsettled in the scientific community."[25] In contrast, Judge Casey of the Southern District of New York, called the D & X procedure "gruesome, brutal, barbaric, and uncivilized,"[26] and found that abortion procedures "subject fetuses to severe pain."[27] These diverse opinions arise, in part, due to differing definitions of the words "feel" and "pain."[28]

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[24] *Planned Parenthood Federation v. Ashcroft*, 320 F.Supp. 2d 957, 997 (N.D. Cal. 2004).

[25] *Id.* at 1001.

[26] *Nat'l Abortion Federation v. Ashcroft*, 330 F.Supp. 2d 436, 479 (S.D.N.Y. 2004).

[27] *Id.*

[28] *See* Fran Lang Porter, *et al.*, *Pain and Pain Management in Newborn Infants: A Survey of Physicians and Nurses*, 100 PEDIATRICS 626 (1997) (stating that "ample data now indicate that the neurophysiologic basis for pain is established by the end of the second trimester of pregnancy"); Royal College of Obstetricians and Gynaecologists, FETAL AWARENESS: REPORT OF A WORKING PARTY (1997) (providing that practitioners who undertake termination of pregnancy at 24 weeks or later should consider the requirements for fetal analgesia or sedation prior to fetocide); American Academy of Pediatrics & Canadian Paediatric Society, *Committee on Fetus and Newborn, Prevention and Management of Pain and Stress in the Neonate*, 105 PEDIATRICS 454 (2000) (stating that "[b]y late gestation, the fetus has developed the anatomic, neurophysiological, and hormonal components necessary to perceive pain."); Commission of Inquiry into Fetal Sentience, THE RAWLINSON REPORT (1996) ("the fetus may be able to experience suffering from around 11 weeks of development"), available at www.care.org.uk; Royal College of Physicians and Surgeons of Alberta, *Policy on Termination of Pregnancy* (2000) (stating that "[i]n some circumstances, in order to reduce suffering where intervention is necessary to terminate pregnancy after 20 weeks/0 days, patient and physician may consider feticide prior to initiating the termination procedure"). *See also* B.A.

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Some define pain as requiring conscious recognition. "Pain is a subjective sensory and emotional experience that requires the presence of consciousness to permit recognition of a stimulus as unpleasant."[29] Scientists in this camp define "feels" to mean only those responses that reflect some self-awareness or conscious appreciation of pain. "Because pain is a psychological construct with emotional content, the experience of pain is modulated by changing emotional input and may need to be learned through life experience."[30]

In the absence of consciousness, doctors in this group argue that the most researchers can conclude is that the human fetus "reacts to physical stimulation."[31] "Whether the fetus feels pain, however, hinges not on its biological development but on its conscious development. Unless it can be shown that the fetus has a conscious appreciation of pain after 26 weeks, then the response to noxious stimulation must still essentially be reflex, exactly as before 26 weeks."[32]

Robinson, *Can a Fetus Feel Pain?*, (2001), available at http://www.religioustolerance.org/abo_pain.htm.

[29] Susan J. Lee, *et al.*, *Fetal Pain: A Multidisciplinary Systematic Review of the Evidence*, 294 JAMA 947 at 948 (2005).

[30] Lee, *Fetal Pain* at 949. *See also* Testimony of Dr. Stuart Derbyshire, Commission of Inquiry into Fetal Sentience (Mar. 6, 1996), available at http://www.care.org.uk/issues/fs/derbyshr.htm, and Zbigniew Szawarski, *Commentary: Probably No Pain in the Absence of "Self,"* 313 BRIT. MED. J. 796 (1996), available at http://www.bmj.com/cgi/content/full/313/7060/796.

[31] Hugh Muir, *When does pain begin?*, THE DAILY TELEGRAPH, Sept. 28, 1996, at 8. "Groups such as the Birth Control Trust, whose director Ann Furedi co-wrote one of the papers, admit that the foetus reacts to physical stimulation, such as procedures involving needles, from around 12 to 14 weeks. They agree that stress levels can rise in these circumstances. But they argue that the mere reaction to physical stimuli does not automatically indicate the feeling of pain." *Id.*

[32] *Id.*

This requirement of consciousness, as a predicate to the experience of pain, has been rejected by other physicians. These doctors argue that observed physiological[33] and behavioral responses[34] to stimuli are reliable indicators of pain, particularly for those individuals who are incapable of the self-reporting that is seemingly required for identification of self-awareness or consciousness.[35] While conceding the lack of perfect correspondence between behavioral and physiological indicia and the actual experience of pain, these physicians note that self-reports of pain and the actual experience of pain also lack a perfect correspondence.[36] In the absence of the ability to self-report, physical evidence of pain-like responses should be viewed as "infantile forms of self-report and should not be discounted as 'surrogate measures' of pain."[37] In the face of physiological and behavioral responses to noxious stimuli, these physicians assert that the burden of proof shifts to those

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[33] Physiological changes include changes in heart rate or the increased production of stress hormones. Parliamentary Office of Science & Tech., Advice to the Department of Health, in Fetal Awareness 3 (Feb. 1997), available at http://www.parliament.uk/post/pn094.pdf.

[34] *Id.* Behavioral changes include withdrawal of affected body parts, crying, and facial expressions. *Id.*

[35] *See* K.J.S. Anand & Kenneth D. Craig, *Editorial: New Perspectives on the Definition of Pain*, 67 PAIN 3 (1996) (stating that "because self-report may be absent or a faulty source of inference, nonverbal behavioral information is often needed and used for pain assessment."). *See also* American Academy of Pediatrics & Canadian Paediatric Society, *Prevention and Management of Pain and Stress in the Neonate*, 105 PEDIATRICS 454 (2000), available at http://www.aap.orgpolicy/re9945.html.

[36] Anand & Craig, *supra* note 35, at 3.

[37] *Id.* at 5. *See also* Vivette Glover & Nicholas Fisk, *Do Fetuses Feel Pain?*, 313 BRIT. MED. J. 796 (1996) (arguing that fetal stress responses may be the best indices of pain currently available).

who challenge the existence of fetal pain rather than having to be borne by those who seek to alleviate it.[38]

Physicians subscribing to the view that fetal pain should be presumed in cases involving physiological and behavioral responses often reinforce their argument by referring to the development of the fetal nervous system. From the perspective of neurological development, the key to answering the question of whether fetuses experience pain depends primarily upon the development and function of the various regions of the brain. While simple reflex responses can be observed as early as seven weeks of gestation, there is no involvement of the brain. In the

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[38] John Wyatt, *When Do We Begin to Feel the Pain?*, THE GUARDIAN, Oct. 24, 1996, at 2.

> While responsible scientists have a duty to emphasise what they don't know, doctors have a duty of care that should lead them to err on the side of caution. If there is a possibility of lasting harm, we must act in the best interests of our patients even when the evidence is ambiguous. We should, in the words of Glover [a clinical scientist in the psychobiology group at Queen Charlotte's and Chelsea Hospital in London], 'give the foetus the benefit of the doubt', and extend the use of effective pain relief to surgical procedures before birth.

Id. See also S. Vanhatalo & O. Van Nieuwenhuizen, *Fetal Pain, Brain and Development*, May 24, 2000 (stating that the proper response to evidence of fetal response to noxious stimuli is to avoid or treat any possibly noxious stimuli rather than speculate on the possible emotional experiences of pain by the fetus or neonate). *See also*, Mark Owens, *Pain in Infancy: Conceptual and Methodological Issues*, 20 PAIN 213, 230 (Nov. 1984).

> If the assumption that infants experience pain is correct, then the benefits are measured by a decrease in needless human suffering. The cost of a mistaken assumption of infant pain would be to waste the effort. Costs and benefits come down squarely on the side of assuming that infants do experience pain. The burden of proof should be shifted to those who maintain that infants do not feel pain.

Id.

absence of any brain activity there can be no perception of pain, according to the current consensus of the medical community. Where medical opinion divides is over whether pain perception by the human fetus is controlled exclusively by the cortex or whether the thalamus and lower brain stem can generate perceptions of pain.

In October 1997, the Royal College issued its Working Party Report on Fetal Awareness. Based upon the physiological and behavioral evidence, the Working Party recommended that practitioners who undertake procedures directly on the fetus, or who undertake termination of a pregnancy at twenty-four weeks or later, should consider the requirements of fetal analgesia or sedation prior to the procedure.[39] In 1999, the British Department of Health requested that the Medical Research Council review the report of the Royal College and make recommendations as to areas where further scientific research was needed.[40] As a result of their study, members of the Council's expert panel found that the sensory pathways and connections to the cortex necessary for pain perception are present or begin to form at twenty weeks gestation.[41]

In the summer of 2000, the Alberta College modified its policy on termination of pregnancy to "reduce suffering where intervention is necessary to terminate pregnancy after 20 weeks/0 days" by recommending that the fetus be

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[39] *Id. See also* David James, *Recent Advances: Fetal medicine*, 316 BRIT. MED. J. 1580 (1998).

[40] Medical Research Council, *Summary of Report on Fetal Pain* (2001), available at http://www.mrc.ac.uk/index/publications-publications/publications-research_reviews/publications-fetal_pain_summary_report.htm.

[41] *See* Roger Highfield, *Unborn Child Can Feel Pain at 20 Weeks, Say Researchers*, THE DAILY TELEGRAPH, Aug. 28, 2001, at 2.

killed via intracardiac injection of potassium chloride prior to initiating the termination procedure.[42]

During testimony regarding the federal partial-birth abortion ban before the District Court of Northern California, Dr. Katharine Sheehan, medical director for Planned Parenthood of San Diego and a witness for the plaintiffs, testified that her clinic offered to administer digoxin to induce fetal demise prior to every abortion related to pregnancies that had progressed to twenty-two weeks of gestation or more. Every one of her patients had accepted the offer. Dr. Sheehan also testified that Planned Parenthood of Los Angeles routinely offered to induce fetal demise prior to aborting fetuses of twenty-one weeks or older. *Planned Parenthood Federation v. Ashcroft*, Tr. Vol. II at 243:1-2 & 244 in *Planned Parenthood Federation v. Ashcroft*, 320 F.Supp. 2d 957 (N.D. Cal. 2004).

While the District Court found that "nearly everyone agrees that it is not always possible to kill the fetus by injection," 331 F.Supp. 2d at 1027-29, based on trial testimony, there is no analysis of the Congressional record on this point. In fact, in addition to the mandates of fetocide prior to late-term abortions by the Royal Colleges of Obstetricians and Gynaecologists of Great Britain and the Canadian province of Alberta, the most current American medical text on abortion recommends the practice.

> The degree of softening of fetal cortical bone affects the amount of dilation needed for D & E. Softening is facilitated by fetal demise. Noticeable cortical softening begins to occur as soon as 16-24 hours after demise. The most common pharmacological agents used to induce demise in developed countries are potassium chloride (KCl) and digoxin (Ch. 11).

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[42] College of Physicians and Surgeons of Alberta, *Termination of Pregnancy* (2000).

> Wright and Watson reported successful use of 1 mg. of digoxin as a fetocidal agent for 5000 D & E abortions at 19 weeks' gestation or more. They injected the drug transabdominally into the fetus or amniotic fluid without ultrasonographic guidance. Apart from a few transient episodes of maternal bradycardia that resolved spontaneously, no adverse effects occurred despite instances of inadvertent intramyometrial and systemic injection. Fetal death was confirmed in all cases by ultrasonography within 30 minutes. Another provider of later abortions reported success in inducing demise without serious complications using the same dose of digoxin and a similar injection protocol in more than 10,000 induction/D & E procedures at or beyond 18 weeks' gestation.

Warren Haskell *et al.*, *Surgical Abortion After the First Trimester* in A CLINICIAN'S GUIDE TO MEDICAL AND SURGICAL ABORTIONS (Maureen Paul *et al.*, eds. 1999) at 131.

Congress was aware of the developing consensus on the existence of fetal pain at least as early as twenty weeks as it crafted the Partial-Birth Abortion Ban of 2003 and sought to respond. H.R. Rep. 108-58 at 4 and 22-23.

Yet the District Court ruled that the existence of fetal pain is irrelevant, requiring that Congress give no consideration to anything other that the speculative interests of women, and then only as described by those who would seek an ever-expanding abortion license.[43]

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[43] *Compare Nat'l Abortion Federation v. Gonzales*, 437 F.3d at 312 (2nd Cir. 2006)

> Regardless of whether a partial-birth abortion terminates the life of a statutory "person," allowing a physician to destroy a child as long as one toe remains within the mother would place society on the path towards condoning infanticide. Preventing the death of an infant in the process of being born

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> If a judge reads *Stenberg* believing that he or she has an obligation to apply it in good faith, it is impossible to argue with a straight face that (1) causing a nonviable fetus to die a gasping, suffocating, and sometimes prolonged, death (induction) inflicts less pain than a single strike to the skull (the banned technique), and (2) therefore the physician's judgment about which procedure is safer for the woman must give way to government officials' aesthetic preferences. Prior to viability, the precedent that I have sworn to follow dictates that the well-founded health interests of the woman are always superior to Congress' otherwise laudable, but ultimately capricious, concern for fetal pain.

331 F.Supp. 2d at 1029. The District Court's characterization of Congressional attempts to address this Court's concern that other forms of abortion remain available, while prohibiting or limiting a practice that American citizens finds inhumane and abhorrent is further evidence of its disregard for the Constitutional process of collective self-governance.

This is clearly contrary to the teachings of *Planned Parenthood of Southeastern Pa. v. Casey,* 505 U.S. 833 (1992). "The political processes of the State are not to be foreclosed from enacting laws to promote the life of the unborn and to ensure respect for all human life and its potential." *Id.* at 871 (plurality opinion). "The State's constitutional authority is a vital means for citizens to address these grave and serious issues, as they must if we are to progress in knowledge and understanding and in

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> safeguards those infants who have been completely separated from their mothers.
>
> I find the current expansion of the right to terminate a pregnancy to cover a child in the process of being born morally, ethically, and legally unacceptable.

Id. (Straub, J. dissenting).

the attainment of some degree of consensus." *Stenberg v. Carhart*, 530 U.S. 914, 957 (2000) (Kennedy, J. dissenting).

CONCLUSION

Congress carefully considered and rejected Respondents' argument that partial-birth abortion is necessary to properly respond to maternal health risks. Congress also vigorously debated the constitutionality of the Act. The Constitution does not require that Congress stay its hand merely because some in the medical profession speculate that there may be some condition that would justify the use of a procedure that Congress determines to be harmful. Nor does the Constitution require Congress to bow to the opinion of those who would value professional independence over the common good.

For the foregoing reasons, *Amici* request that this Court reverse the judgments of the District Court and Court of Appeals.

Respectfully submitted,

TERESA STANTON COLLETT
Counsel of Record

APPENDIX A

[LOGO]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control and Prevention (CDC)
Atlanta, GA 30333

Mr. Walter M. Weber
Senior Litigation Counsel
American Center for Law & Justice
201 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Weber:

We appreciate your interest in the Centers for Disease Control and Prevention's (CDC) efforts to collect and publish maternal mortality statistics (including those related to abortion). CDC makes every effort to identify all such deaths and to present maternal mortality statistics using established scientific methods.

The maternal mortality rate is computed as all maternal deaths per 100,000 live births. In contrast, the measure used for abortions is a case-fatality rate which is computed per 100,000 legal abortions. These measures are conceptually different and are used by CDC for different public health purposes.

CDC calculates the maternal mortality rate per 100,000 live births for the following reasons:

1. To maintain comparability in long term trends for the United States. Estimates of the number of pregnancies (including live births, miscarriages or stillbirths, and induced abortions)

in the United States have been published only since the 1970s.

2. The live birth component of the pregnancy estimates is highly reliable. Virtually all births are counted in every year. Estimates of all abortions are based on CDC's abortion surveillance system, which relies on state abortion reporting systems. Estimates of stillbirths, ectopic pregnancies, and miscarriages are based on survey data and are subject to significant sampling error, particularly for smaller population subgroups. Estimates of stillbirths and miscarriages are based on pregnancy history data from the National Survey of Family Growth (NSFG). The NSFG is conducted periodically, every 5 to 7 years. The data are subject to sampling error, particularly for smaller population subgroups. For information on the estimation methodology, see www.cdc.gov/nchs/data/series/sr_21/sr21_056.pdf.

3. To maintain international comparability. Many other countries cannot adequately estimate the number of pregnancies, especially those in which abortion is illegal. Information on miscarriage and stillbirth also varies considerably in completeness. In the interest of international comparability, the World Health Organization has specified that the number of live births should be used for the denominator of the maternal mortality rate.

Adjusting the maternal mortality rate for gestational stage is not statistically feasible, because this requires data that are not currently completely available. The Pregnancy Mortality Surveillance System (PMSS) relies primarily on

death certificates which do not typically provide this information. Gestational age may be available for some maternal deaths in cases where linkage with other records (e.g., birth certificates, fetal death reports) is possible. Information on gestational age for induced abortions is available in about 42 states or jurisdictions.

CDC recognizes that despite efforts to count all maternal deaths (including those abortion-related) in the United States, some remain uncounted. The death itself is reported but accurate information on the cause may not be provided. CDC estimates that maternal deaths in general are underreported by 30 to 150 percent (see www.cdc.gov/mmwr/preview/mmwrhtml/sl5202as.htm). The nature of the surveillance systems make it difficult to obtain complete data. The PMSS compiles data from 50 states, the District of Columbia, and New York City. Abortion surveillance involves data from 47 states, District of Columbia, and New York City. These systems are voluntary (CDC does not provide remuneration for data) and rely primarily on death certificate data which may or may not provide information that indicates the death was maternal or abortion-related. In the case of deaths associated with induced abortion, CDC also uses searches of computerized print media databases (Lexis-Nexis) to identify additional cases.

At CDC we are very committed to improving data collection systems and providing the most accurate and reliable data on all aspects of maternal and infant health. I hope this information is helpful.

Sincerely,

/s/ Julie Louise Gerberding
Julie Louise Gerberding
M.D., M.P.H.
Director

APPENDIX B

National Abortion Federation, et al. v. Ashcroft
U.S. District Court, Southern District of New York
The Honorable Richard Conway Casey, Judge

DAY SEVEN: Thursday, April 8, 2004.
Excerpts from cross- examination of Dr. Stephen T. Chasen:

* * *

[165] Q. You change the conclusion in your concluding paragraph of your first draft, didn't you, Doctor?

A. Yes.

Q. There you had stated, "our data affirmed that D&E, after 20 weeks' gestation with intact extraction when performed by experienced physicians, is as safe as D&E with disarticulation."

Correct?

A. Correct.

Q. And you changed that in your next draft to, "our data affirmed that abortion after 20 weeks' gestation with intact D&X appears to have similar complication rates as dilation and evacuation when performed by experienced physicians."

Correct?

A. Correct.

Q. And you cannot state that one technique is superior to the other, can you, Doctor?

A. Not based solely on the data in a retrospective study with certainty.

Q. Not based solely on the data in your retrospective study, correct, Doctor?

[166] A. I cannot prove it or state it with certainly [sic] TEU.

Q. You were also criticized for your conclusion that, "subsequent obstetric outcomes are similar between the two groups."

Correct?

A. Correct.

Q. And that related to your finding about preterm birth, correct?

A. Spontaneous preterm birth.

Q. And because you are only able to follow up on 62 pregnancies of your group out of 363 patients, the reviewers identify a potential weakness to your conclusion on that score, correct, Doctor?

A. Correct.

Q. Now, you could have contacted the remaining 321 women to determine the absolute number of subsequent pregnancies that occurred, couldn't you?

A. We could have, but we had no guarantee of obtaining reliable data that way. That –

Q. Well you could have asked them for permission to study the medical records to assist you in performing your study, isn't that right?

A. We could have. But, again, I don't think that would have led to uniformly reliable data.

Q. Now, the spontaneous preterm birth occurred in your study [167] in women who had undergone D&X at almost twice the rate of D&E by dismemberment, correct?

A. There was no statistical difference in the rate.

Q. Almost twice the rate, isn't that right, Doctor?

A. Yes. But that was not statistically different.

Q. Well, wouldn't you agree that the quality of your conclusion may be affected by the number of patients that you were able to subsequently follow who had pregnancies and delivered at Cornell?

A. No, I wouldn't agree.

Q. Directing your attention to page 39, line 20 in your deposition in this case:

"Q How about the quality of your conclusion? Does that depend, in any way, on the number of patients that you were able to subsequently follow at your institution?

"A It might.

"Q In what way?

"A As we addressed the conclusion we did not assess pregnancies that were cared for outside of our hospital.

"Q And why does that affect the quality of your conclusion, Doctor?

"A Can you read back the last question as to the quality of the conclusion, my response to that question.

Where upon the question and answer were read back to you [168]

"A And read back the current question now.

Where upon the current question was read back to you.

"A Answer it might affect the quality of the conclusion if, as we acknowledge in paragraph 2, it could introduce bias.

"Q What do you mean by that?

"A Hypothetically the patients who underwent D&E at our hospital and delivered elsewhere may have had a higher or lower rate of spontaneous preterm birth.

"Q And why, as stated in your report, do you think the significant bias would be unlikely?

"A We believe a significant bias would be unlikely.

"Q Why?

"A We did not determine where patients would delivered.

"Q But KPWR [sic] would a significant bias be unlikely?

"A We didn't envision a scenario where a significant bias would be unlikely

"Q But what's the basis for that statement in the study?

"A It's in the comments section, it's our opinion.

"Q What what is the basis for your opinion?

"A Our lack of ability to envision such a scenario.

"Q And why couldn't you envision such a scenario?

"A We did not.

[169] "Q Why?

"A I don't have anything to add."

Q. Were you asked those questions, did you give those answers at your deposition in this case?

MR. HUT: Objection, your Honor. I believe that Ms. Gowan P-S read the last word at line 21 on page 41. In the copy that I have before me it is likely and I believe you said unlikely.

MS. GOWAN: Oh. That's correct.

Q. Were you asked those questions did you give those answers at your deposition, Doctor?

A. Yes.

* * *

[183] Q. You testified this morning in response to counsel's questions that in your opinion intact D&E is the safest perform an abortion as compared to dismemberment D&E, right?

A. When I can technically accomplish – if I can do either, that the intact variation is safer.

Q. Your study doesn't support that conclusion, does it, Doctor?

A. I think my study does support that conclusion.

Q. You testified that in your opinion the intact D&E has safety advantages over D&E by dismemberment because the procedure is quicker, right?

A. Yes.

Q. Your study doesn't support that conclusion either, does it?

A. I don't think my data are inconsistent with that conclusion.

Q. Procedure time was the same, wasn't it?

A. It was the same, but in those cases with intact extraction', that group, based on appropriate statistical tests with which the' reviewers and editors agreed, were at higher [184] gestational ages as a whole than women who had D&E with disarticulation.

Q. You testified that the intact D&E has safety advantages over D&E by dismemberment because there is less blood loss with the procedure, correct?

A. Correct.

Q. And your study doesn't support that conclusion either, does it; the blood loss is the same?

A. When it is the same in two cohorts, one of when I say is in my opinion at considerably higher risk of hemorrhage, then it STKUZ [sic] support that advantage of safety advantage of D&E with intact extraction.

Q. 80 percent of the blood loss that occurs after the placenta has been delivered, which is after the fetus has been removed from the woman, correct?

A. Correct.

Q. That is not blood loss from perforations or lacerations, is it?

A. It's not. [> check the question<]

Q. Wouldn't you agree that you would expect that if there was a benefit to less passes with instruments, you would have less procedure time or less blood loss with intact D&E?

A. Yes.

Q. Your study doesn't show that you do, does it?

A. Again, the cohort in which we used the intact extraction [185] and achieved the same blood loss in the same operative time would be expected based on advanced gestational age to have increased operative time and increased blood loss. So, again I think those safety advantages are not inconsistent with the data in the study.

Q. You don't make that claim in your study, do you?

A. I don't make that claim in the study, no.

* * *